STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for the Investigation of Complaints IN00131980, IN00132305, and IN00132735. Complaint IN00131980-Substantiated. Federal/state deficiencies related to the allegations are cited at F465. Complaint IN00132305-Substantiated. Federal/state deficiencies related to the allegations are cited at F223, F225, F226 and F441. Complaint IN00132735- Substantiated. Federal/state deficiencies related to the allegations are cited at F309, F441 and F514. Survey dates: July 22, 23, and 24, 2013 Facility number: 000476 Provider number: 155446 AIM number: 100290870 Survey team: Christine Fodrea, RN TC Census bed type: SNF/NF: 115 Total: 115	F000000	This Plan of Correction is the center's credible allegation of compliance.Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alledged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Census payor type: Medicare: 20 Medicaid: 68 Other: 27 Total: 115 Sample: 7 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality Review completed on July 31, 2013, by Brenda Meredith, R.N.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000223 SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to ensure residents were free from feelings of abuse for 1 of 3 residents reviewed in a sample of 7 (Resident # S) Findings include: Resident #S' record was reviewed 7-23-2013 at 9:30 AM. Resident #S' diagnoses included but were not limited to: depression, high blood pressure, and osteoporosis. Resident #S' 5- day Minimum Data Set assessment (MDS), dated 7-19-2013, indicated Resident #S had a Brief Interview for Mental Status (BIMS) score of 13. The score indicated Resident #S was alert and oriented and could answer questions appropriately. In an interview on 7-22-2013 at 8:45 AM, LPN #1 indicated Resident #S was transferred using a slide board.	F000223	F 223- 1. Social Services/designee spoke to Resident # S regaurding her feelings. Resident voiced she is happy to be back at the facility. 2.All residents were interviewed to assure that they feel free from feelings of abuse. No other residents identified to be affected by deficiency. 3. Facility will do quarterly QA rounds interviewing residents during IDT walking rounds and asking residents if they feel safe and free from feelings of abuse. 4. The CMS form for Resident interview and observation will be utilized with the IDT walking rounds. These rounds will be completed quarterly and upon admission to ensure residents are free from feelings of abuse. Every resident that is interviewable will be interviewed at least every 30 days during IDT walking rounds and/or Angel Rounds. These forms will be turned into Admin/designee and be reviewed monthly in QA and quarterly by the Medical Director for six months. 5. Facility will be compliant by August 23, 2013	08/23/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	In an interview on 7-23-2013 at 11:45 AM, Resident #S indicated she was to be transferred by slide board, and on 7-5-2013, CNA #2 and CNA #3 came into the room to transfer her. CNA #3 had the side board. CNA #2 assisted Resident #S to her side and face her. CNA #3 was at Resident #S' back. CNA #2 then pivoted Resident #S before CNA #3 could assist her with the transfer or the side board. Resident #S indicated her knees hit the floor, and thought CNA #2 had dislodged or broken her ankle. Resident #S indicated she told CNA #2 and CNA #3 she thought her leg was broken. Resident #S further indicated she could not remember if the nurse checked her leg, but she did have an x-ray and everything was fine. Resident #S additionally indicated she had increased pain because she was transferred improperly. In an interview on 7-23-13 at 1:34 PM, CNA #3 indicated she was in Resident #S room with CNA #2 when CNA #2 pivoted Resident #S. CNA #3 indicated the pivot happened so fast, she did not have time to tell CNA #2 to use the slide board. CNA#3 further indicated Resident #S knees did not touch the floor, but Resident #S did			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicate she thought CNA #2 had broken her leg. CNA #3 indicated the nurse on duty was alerted to the allegation. In an interview on 7-23-20-13 at 1:52 PM, LPN #4 indicated she had been notified on 7-5-2013 at about 2:30 PM, by CNA #2 Resident #S had been transferred, and was complaining CNA #2 had broken her leg. LPN #4 further indicated CNA #2 had told her Resident #S had not fallen or slid to the floor. LPN #4 indicated she assessed the leg Resident #S was complaining was in pain, but did not see any changes, and so nothing further was done. LPN #4 indicated Resident #S told her she had not fallen, and so thought no more of the allegation. LPN #4 indicated she reported the occurrence to the next shift, and the next day when she came in, the nurse giving her report indicated Resident #S had fallen, and was being taken to the hospital because of left leg pain. LPN #4 did not consider the allegation to be abuse. The Medication Administration Record (MAR), dated 7-2013, indicated Resident #S utilized as necessary (prn) pain medication on 7-1 at 9 PM, 7-2 at 4 PM and 8 PM,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	on 7-3 at 5:30 PM, then on 7-5 at 4 PM, and 8 PM and 7-6 at 1:30 AM, 9:40 AM, and 1:40 PM. Resident #S' nurse's notes, dated 7-6-2013 at 6:20 PM, indicated resident had been dropped, ice had been applied to the area, x-ray showed no fracture, but due to increased pain, Resident #S was being transferred to the hospital Emergency Room for evaluation and treatment. There were no nurse's notes dated 7-5-2013 available for review. Review of the current policy titled Abuse Prevention, Intervention, Investigation, and Crime Reporting, dated September 2011, provided by the Administrator on 7-23-2013 at 10:42 AM, indicated: Any form of mistreatment of residents including, but not limited to abuse, neglect, exploitation, involuntary seclusion, or misappropriation is strictly prohibited. 3.1-27(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record	F000225	1.Unable to report incident.	08/23/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	review, the facility failed to ensure an allegation of abuse was reported to the Administrator for 1 of 3 residents reviewed in a sample of 7 (Resident # S) Findings include: Resident #S' record was reviewed 7-23-2013 at 9:30 AM. Resident #S' diagnoses included but were not limited to: depression, high blood pressure, and osteoporosis. Resident #S' 5- day Minimum Data Set assessment (MDS), dated 7-19-2013, indicated Resident #S had a Brief Interview for Mental Status (BIMS) score of 13. The score indicated Resident #S was alert and oriented and could answer questions appropriately. In an interview on 7-22-2013 at 8:45 AM, LPN #1 indicated Resident #S was transferred using a slide board. In an interview on 7-23-2013 at 11:45 AM, Resident #S indicated she was to be transferred by slide board, and on 7-5-2013, CNA #2 and CNA #3 came into the room to transfer her. CNA #3 had the side board. CNA #2 assisted Resident #S to her side and face her. CNA #3 was at Resident #S' back.		Anyone will be reported to the Administrator immediately and reported to State per Federal guidelines. Staff to be educated ongoing throughout the month and throughout the year and yearly as required by Federal guidelines on how, when and who to report abuse allegations to. 2. .Facility reveiwed last 30 days of grievances to ensure allegations of abuse were reported timely. Administrator educated on guidelines for reporting incidents. 3. Administrator educated on guidelines for reporting incidents. Administrator/designee will review grievance logs monthly to ensure allegations of abuse were reported. 4. Results will be forwarded to the QA committee monthly for two months and then quarterly for 6 months after. Admin/designee to conduct 5 random staff interviews weekly for 1 month, 1 time weekly for one month and then monthly for 4 months. Every resident that is interviewable will be interviewed at least every 30 days during IDT walking rounds and/or Angel Rounds. 5. Facility will be compliant by August 23, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	CNA #2 then pivoted Resident #S before CNA #3 could assist her with the transfer or the side board. Resident #S indicated her knees hit the floor, and thought CNA #2 had dislodged or broken her ankle. Resident #S indicated she told CNA #2 and CNA #3 she thought her leg was broken. Resident #S further indicated she could not remember if the nurse checked her leg, but she did have an x-ray and everything was fine. Resident #S additionally indicated she had increased pain because she was transferred improperly. In an interview on 7-23-13 at 1:34 PM, CNA #3 indicated she was in Resident #S room with CNA #2 when CNA #2 pivoted Resident #S. CNA #3 indicated the pivot happened so fast, she did not have time to tell CNA #2 to use the slide board. CNA#3 further indicated Resident #S knees did not touch the floor, but Resident #S did indicate she thought CNA #2 had broken her leg. CNA #3 indicated the nurse on duty was alerted to the allegation. In an interview on 7-23-20-13 at 1:52 PM, LPN #4 indicated she had been notified on 7-5-2013 at about 2:30 PM, by CNA #2 Resident #S had			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	been transferred, and was complaining CNA #2 had broken her leg. LPN #4 further indicated CNA #2 had told her Resident #S had not fallen or slid to the floor. LPN #4 indicated she assessed the leg Resident #S was complaining was in pain, but did not see any changes, and so nothing further was done. LPN #4 indicated Resident #S told her she had not fallen, and so thought no more of the allegation. LPN #4 indicated she reported the occurrence to the next shift, and the next day when she came in, the nurse giving her report indicated Resident #S had fallen, and was being taken to the hospital because of left leg pain. LPN #4 did not consider the allegation to be abuse. Review of the current policy titled Abuse Prevention, Intervention, Investigation, and Crime Reporting, dated September 2011, provided by the Administrator on 7-23-2013 at 10:42 AM, indicated: It is the responsibility of employees to immediately report to the Administrator....any incident of suspected or alleged resident abuse from other residents, staff, family or visitors.... 3.1-28(c)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure the policy prohibiting abuse was implemented for 1 of 3 residents reviewed in a sample of 7 (Resident # S) Findings include: Resident #S' record was reviewed 7-23-2013 at 9:30 AM. Resident #S' diagnoses included but were not limited to: depression, high blood pressure, and osteoporosis. Resident #S' 5- day Minimum Data Set assessment (MDS), dated 7-19-2013, indicated Resident #S had a Brief Interview for Mental Status (BIMS) score of 13. The score indicated Resident #S was alert and oriented and could answer questions appropriately. In an interview on 7-22-2013 at 8:45 AM, LPN #1 indicated Resident #S was transferred using a slide board.	F000226	1. Anyone will be reported to the Administrator immediately and reported to State per Federal guidelines. Staff to be educated ongoing throughout the month and throughout the year and yearly as required by Federal guidelines on how, when and who to report abuse allegations to. 2. .All residents were interviewed to assure that they feel free from feelings of abuse. No other residents identified to be affected. 3. Facility will do quarterly QA IDT walking rounds interviewing residents and asking them if they feel safe and free from feelings of abuse. Any situation identified as an allegation of abuse will be reported to the Administrator and then reported to the State. 4. The CMS form for Resident interview and observation will be utilized with the IDT walking rounds. Every resident that is interviewable will be interviewed at least every 30 days during IDT walking rounds and/or Angel Rounds. These rounds will be completed quarterly and upon admission to ensure residents are free from feelings of abuse. Any reports of abuse will immediately be reported to the State. 5. Facility will be compliant by	08/23/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	In an interview on 7-23-2013 at 11:45 AM, Resident #S indicated she was to be transferred by slide board, and on 7-5-2013, CNA #2 and CNA #3 came into the room to transfer her. CNA #3 had the side board. CNA #2 assisted Resident #S to her side and face her. CNA #3 was at Resident #S' back. CNA #2 then pivoted Resident #S before CNA #3 could assist her with the transfer or the side board. Resident #S indicated her knees hit the floor, and thought CNA #2 had dislodged or broken her ankle. Resident #S indicated she told CNA #2 and CNA #3 she thought her leg was broken. Resident #S further indicated she could not remember if the nurse checked her leg, but she did have an x-ray and everything was fine. Resident #S additionally indicated she had increased pain because she was transferred improperly. In an interview on 7-23-13 at 1:34 PM, CNA #3 indicated she was in Resident #S room with CNA #2 when CNA #2 pivoted Resident #S. CNA #3 indicated the pivot happened so fast, she did not have time to tell CNA #2 to use the slide board. CNA#3 further indicated Resident #S knees did not touch the floor, but Resident #S did		August 23, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicate she thought CNA #2 had broken her leg. CNA #3 indicated the nurse on duty was alerted to the allegation. In an interview on 7-23-20-13 at 1:52 PM, LPN #4 indicated she had been notified on 7-5-2013 at about 2:30 PM, by CNA #2 Resident #S had been transferred, and was complaining CNA #2 had broken her leg. LPN #4 further indicated CNA #2 had told her Resident #S had not fallen or slid to the floor. LPN #4 indicated she assessed the leg Resident #S was complaining was in pain, but did not see any changes, and so nothing further was done. LPN #4 indicated Resident #S told her she had not fallen, and so thought no more of the allegation. LPN #4 indicated she reported the occurrence to the next shift, and the next day when she came in, the nurse giving her report indicated Resident #S had fallen, and was being taken to the hospital because of left leg pain. LPN #4 did not consider the allegation to be abuse. The Medication Administration Record (MAR) dated 7-2013 indicated Resident #S utilized as necessary (prn) pain medication on 7-1 at 9 PM, 7-2 at 4 PM and 8 PM, on 7-3 at 5:30			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	PM, then on 7-5 at 4 PM, and 8 PM and 7-6 at 1:30 AM, 9:40 AM, and 1:40 PM. Resident #S' nurse's notes dated 7-6-2013 at 6:20 PM indicated resident had been dropped, ice had been applied to the area, x-ray showed no fracture, but due to increased pain, Resident #S was being transferred to the hospital Emergency Room for evaluation and treatment. There were no nurse's notes dated 7-5-2013 available for review. review of the current policy titled Abuse Prevention, Intervention, Investigation, and Crime Reporting, dated September 2011, provided by the Administrator on 7-23-2013 at 10:42 AM indicated: Any form of mistreatment of residents including, but not limited to abuse, neglect, exploitation, involuntary seclusion, or misappropriation is strictly prohibited. The policy further indicated It is the responsibility of employees to immediately report to the Administrator....any incident of suspected or alleged resident abuse from other residents, staff, family or visitors.... 3.1-28(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to ensure a surgical wound was free of colostomy drainage for 1 of 3 residents reviewed with wounds in a sample of 7. (Resident #T) Findings include: Resident #T's record was reviewed 7-24-2013 at 10:36 AM. Resident #T's diagnoses included but were not limited to: high blood pressure, diabetes, and GERD (Gastroesophageal reflux disease) . Admitting nurse's assessment indicated Resident #T was admitted with a midline abdominal incision approximately 18.6 centimeters long. Assessment further indicated a colostomy was located approximately 3 centimeters from the incision on Resident #T's abdominal incision. Nurse's notes, dated 7-7-2013 at 2 PM, indicated Resident #T's	F000309	1.Resident T no longer resides in the facility. 2. All residents that have colostomy's and wounds were reviewed in the facility. No other issues were noted with residents with colostomy and wounds 3. In servicing has started with licensed staff on colostomy and colostomy procedures and this will be ongoing. Licensed staff were in serviced on wound vacs on July 26 th and July 29 th by webinar with KCI. Ongoing education to continue. 4. All resident with the colostomy and wound vacs will be monitored by DON/designee on random shifts to assure the colostomy and the wound vac are applied properly. Monitoring will be 5x/week for 1 month and then weekly for 1 month and then monthly for six months. Results will be reviewed at QA monthly and reviewed by the MD on a quarterly basis. 5. Facility will be compliant by August 23, 2013	08/23/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	colostomy was leaking into the wound bed. The notes further indicated attempts to redress the wound was unsuccessful. In an interview on 7-24-2013 at 11:29 AM, LPN #5 indicated Resident #T's colostomy was difficult to manage, there was no order for stomahesive on admission and the colostomy device did not adhere easily to the skin. LPN #5 further indicated she had informed her supervisor, but no help had been given. In an interview on 7-24-2013 at 1:48 PM, LPN #6 indicated the stool from the colostomy was sucked into the wet to dry dressing. LPN #6 further indicated she asked her supervisor for assistance with the colostomy, but no assistance had been given. In an interview on 7-24-2013 at 1:37 PM, RN #7 indicated she had not been aware Resident #T's colostomy had been leaking into the wound and interventions to prevent further wound contamination should have been attempted. RN #7 further indicated the staff should have charted any intervention they attempted. 3.1-37(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to	F000441	1.Staff was in serviced July 25, 2013 and continue to be in serviced ongoing	08/23/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	ensure used gloves were disposed of properly in one room reviewed and soiled linen was disposed of properly in two rooms reviewed. this had the potential to affect 2 residents on the west hall. (Resident #S and Resident #R) Findings include: 1. Resident #S' record was reviewed 7-23-2013 at 9:30 AM. Resident #S' diagnoses included but were not limited to: depression, high blood pressure, and osteoporosis. During an observation on 7-23-2013 at 10:25 AM, a glove, inside another glove turned inside out was observed lying in a chair in the resident room. Additionally, a towel with a partially dried brown spot on it was observed in a chair on top of a pillow. In an interview on 7-23-2013 at 10:26 AM, CNA #8 indicated the glove should have been thrown away in the trash and the towel should have been placed in the dirty linen. 2. Resident #R's record was reviewed 7-22-2013 at 2:32 PM. Resident #R's diagnoses included but were not limited to: depression, diabetes, and osteoarthritis.		on proper disposal of gloves and soiled linen. 2. All rooms have been observed and any dirty linens or gloves were to be removed immediately. No other residents identified to be affected. 3. Staff was in serviced July 25, 2013 and continue to be in serviced ongoing on proper disposal of gloves and soiled linen. 4. All staff will monitor that gloves and soiled linen will be disposed of properly. Angel Rounds to include monitoring of soiled linens and gloves in resident rooms 5x/week on random shifts during rounds. This monitoring will take place daily for 1 month, weekly for 1 month and then monthly for 6 months. Results will be reviewed at QA monthly and reviewed by the MD on a quarterly basis for six months. 5. Facility will be compliant by August 23, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	In an observation on 7-22-2013 at 2:10 PM a towel with a large brown spot covering about 1/2 the towel was observed on Resident #R's bedside stand. In an interview on 7-23-2013 at 8:45 AM, Resident #R indicated soiled linen was often left in the room for more than one shift. Resident #R's most recently completed quarterly Minimum Data Set (MDS) dated 6-13-2013 indicated her Brief interview for mental status (BIMS) score was 15 indicating Resident #R was alert and oriented and able to answer questions appropriately. 3.1-19(g)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to maintain a comfortable environment in 2 of 5 resident rooms reviewed for comfortable room temperatures on a sample of 7. (Room of Resident #R and Confidential Room)This had the potential to affect all residents residing in the facility. Findings include: 1. Resident #R's record was reviewed 7-22-2013 at 2:32 PM. Resident #R's diagnoses included but were not limited to: depression, diabetes, and osteoarthritis. During an environmental tour on 7-22-2013 at 9:38 AM, the air conditioner in Resident #R's room was observed to be on, and air coming from the air conditioner was measured at 77 degrees. When the air conditioner was checked, the compressor would not turn on despite manipulation. In an interview on 7-2--2013 at 9:38 AM, the Maintenance Director	F000465	1. Maintenance replaced Resident R's PTAC Unit and ensured the PTAC was working properly by checking the temperatures in the room. 2. All PTAC units were inspected by Maintenance. No other units were identified to have any issues at this time. 3. Maintenance or designee to add to preventative maintenance logs and monitor on a monthly basis 4. Administrator will review preventative maintenance logs monthly in QA and by the Medical Director quarterly in QA for 6 months. 5. Facility will be compliant by August 23, 2013	08/23/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated the thermostat on that air conditioner was not working. He further indicated the air conditioners had been checked on the previous Friday. In an interview on 7-22-2013 at 12:15 PM, Maintenance worker #9 indicated he had checked and cleaned the air conditioner filters on all the units. He further indicated he had checked the compressors, and knew the compressor on Resident #R's unit was not operating, but because he was cleaning the filters, he didn't take the time to problem solve the compressor problem. He additionally indicated there were no preventative maintenance records to review regarding how often the air conditioning units in the individual rooms were checked. 2. In a confidential interview on 7-22-2013 at 2:05 PM, a family member indicated there had been repeated issues with the air conditioner in her mother's room. The family member further indicated she addressed the issue with the nurses, but nothing had been done. 3.1-19(h)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review, the facility failed to ensure accurate documentation for 3 of 7 residents reviewed for documentation in a sample of 7. (Resident #R, Resident #S, and Resident #T) Findings include: 1. Resident #R's record was reviewed 7-22-2013 at 2:32 PM. Resident #R's diagnoses included but were not limited to: depression, diabetes, and osteoarthritis. In an interview on 7-22-2013 at 3:34 PM, the SSD indicated Resident #R had been offered an different room when her air conditioner was not working properly, but Resident #R refused the room move.	F000514	1 Administrator informed Social Services that any concerns brought to the SSD will be put on grievance forms, reviewed and forwarded to the appropriate department head to address the concern. 2. Unit Managers will be in serviced by August 8, 2013 that they will review pertinent charting is complete and identify any other high risk residents. No other residents were identified to be affected by this deficiency. 3. DON/designee will audit UMs on 5x/week to ensure that pertinent charting and high risk residents are being documented on. 4. DON/designee will monitor 1x/day for a month, 1x weekly/month and quarterly for six months. Results will be brought to QA committee and reviewed monthly for six months. 5. Facility will be compliant by August 23, 2013	08/23/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A review of Resident #R's Social Services notes indicated no notes were available for review after the 3-13-2013 date. In an interview on 7-23-2013 at 10:12 AM, the SSD (Social Service Director) indicated she could not locate any notes after the 3-13 date, and medical records was unable to locate the notes. 2. Resident #S' record was reviewed 7-23-2013 at 9:30 AM. Resident #S' diagnoses included but were not limited to: depression, high blood pressure, and osteoporosis. In an interview on 7-23-2013 at 11:45 AM, Resident #S indicated she was to be transferred by slide board, and on 7-5-2013, CNA #2 and CNA #3 came into the room to transfer her. CNA #3 had the side board. CNA #2 assisted Resident #S to her side and face her. CNA #3 was at Resident #S' back. CNA #2 then pivoted Resident #S before CNA #3 could assist her with the transfer or the side board. Resident #S indicated her knees hit the floor, and thought CNA #2 had dislodged or broken her ankle. Resident #S indicated she told CNA #2 and CNA #3 she thought her leg			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was broken. Resident #S further indicated she could not remember if the nurse checked her leg, but she did have an x-ray and everything was fine. Resident #S additionally indicated she had increased pain because she was transferred improperly. In an interview on 7-23-13 at 1:34 PM, CNA #3 indicated she was in Resident #S room with CNA #2 when CNA #2 pivoted Resident #S. CNA #3 indicated the pivot happened so fast, she did not have time to tell CNA #2 to use the slide board. CNA#3 further indicated Resident #S knees did not touch the floor, but Resident #S did indicate she thought CNA #2 had broken her leg. CNA #3 indicated the nurse on duty was alerted to the allegation. In an interview on 7-23-20-13 at 1:52 PM, LPN #4 indicated she had been notified on 7-5-2013 at about 2:30 PM, by CNA #2 Resident #S had been transferred, and was complaining CNA #2 had broken her leg. LPN #4 further indicated CNA #2 had told her Resident #S had not fallen or slid to the floor. LPN #4 indicated she assessed the leg Resident #S was complaining was in pain, but did not see any changes,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and so nothing further was done. LPN #4 indicated Resident #S told her she had not fallen, and so thought no more of the allegation. LPN #4 indicated she reported the occurrence to the next shift, and the next day when she came in, the nurse giving her report indicated Resident #S had fallen, and was being taken to the hospital because of left leg pain. LPN #4 did not consider the allegation to be abuse. Resident #S' nurse's notes, dated 7-6-2013 at 6:20 PM, indicated resident had been dropped, ice had been applied to the area, x-ray showed no fracture, but due to increased pain, Resident #S was being transferred to the hospital Emergency Room for evaluation and treatment. There were no nurse's notes dated 7-5-2013 available for review. In an interview on 7-23-2013 at 1:48 PM, LPN #8 indicated incidents should be charted in the nurse's notes. 3. Resident #T's record was reviewed 7-24-2013 at 10:36 AM. Resident #T's diagnoses included but were not limited to: high blood pressure, diabetes, and GERD			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(Gastroesopheageal reflux disease). Admitting nurse's assessment indicated Resident #T was admitted with a midline abdominal incision approximately 18.6 centimeters long. Assessment further indicated a colostomy was located approximately 3 centimeters from the incision on Resident #T's abdominal incision. Nurse's notes, dated 7-7-2013 at 2 PM, indicated Resident #T's colostomy was leaking into the wound bed. The notes further indicated attempts to redress the wound was unsuccessful. In an interview on 7-24-2013 at 11:29 AM, LPN #5 indicated Resident #T's colostomy was difficult to manage, there was no order for stomahesive on admission and the colostomy device did not adhere easily to the skin. LPN #5 further indicated she had informed her supervisor, but no help had been given. In an interview on 7-24-2013 at 1:48 PM, LPN #6 indicated the stool from the colostomy was sucked into the wet to dry dressing. LPN #6 further indicated she asked her supervisor for assistance with the colostomy, but no assistance had been given.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	In an interview on 7-24-2013 at 1:37 PM, RN #7 indicated she had not been aware Resident #T's colostomy had been leaking into the wound and interventions to prevent further wound contamination should have been attempted. RN #7 further indicated the staff should have charted any intervention they attempted. 3.1-50(a)(1)			